U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 08 July 2005

Case No.: 2004-BLA-0024

In the Matter of:

DALLAS L. TAYLOR,
Claimant,

v.

SHARONDALE CORPORATION,
Employer,

KENTUCKY COAL PRODUCERS'
SELF-INSURANCE FUND,
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This proceeding arises from a 1986 claim filed by Dallas L. Taylor for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended ("Act"). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of persons who were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung.

A formal hearing in this case was scheduled for September 8, 2004. On August 24, 2004, the Claimant, through

counsel, requested that the hearing be cancelled and that a decision be made on the record. There was no objection from the Employer or the Director, OWCP, and the Claimant's request for a decision on the record was granted by Order dated August 31, 2004.

Each of the parties has been afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title. The findings and conclusions that follow are based upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

Procedural History

The Claimant, Dallas L. Taylor, filed a claim for benefits under the Act on January 30, 1986 (DX 1).[1] After denial by the Director, a formal hearing was held before Administrative Law Judge Roketenetz on June 6, 1988 (DX 77). A Decision and Order was issued on December 15, 1989, dismissing Loftis Coal Company as the Responsible Operator, finding that Sharondale Coal Company should have been named as the Responsible Operator, and holding that the Black Lung Disability Trust Fund would be liable for any payment of benefits. The Claimant established no elements of entitlement. The Claimant appealed, and on September 28, 1992, the Benefits Review Board ("Board") issued a Decision and Order affirming in part and vacating in part the Decision and Order, and remanding the claim for further consideration (DX 100).

On remand, Judge Roketenetz denied benefits by Decision and Order dated March 31, 1993 (DX 102). The Claimant appealed and on March 30, 1995, the Board remanded the case for a second time. On remand, Judge Roketenetz again denied benefits by Decision and Order dated July 26, 1995, for failure to establish the existence of pneumoconiosis (DX 119). The July 26, 1995, Decision was affirmed by the Board on October 18, 1996 (DX 134), and by the United States Court of Appeals for the Sixth Circuit on September 12, 1997 (DX 136).

[1] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, and "EX" refers to the Employer's Exhibits.

The Claimant filed a request for modification on October 20, 1997 (DX 137). The Director, OWCP, issued a Proposed Order Denying Modification on April 3, 1998 (DX 149), October 1, 1998 (DX 164), and March 11, 1999 (DX 171). The claim was forwarded to the Office of Administrative Law Judges on June 18, 1999 (DX 177). At the request of the Director, the case was remanded for the naming of Sharondale Coal Company as the Responsible Operator (DX 178). The District Director recommended denial of the modification request on January 27, 2000 (DX 178). The Claimant requested a hearing, and the case was referred to the Office of Administrative Law Judges on May 17, 2000. Following a November 14, 2000, hearing, Administrative Law Judge Kane remanded the case back to the District Director for a pulmonary evaluation and a reasoned medical report as required under § 725.406(a).

After completion of the examination, the District Director recommended denial of benefits on November 27, 2002, because the Claimant failed to establish the existence of legal or clinical pneumoconiosis (DX 197). On January 23, 2003, the Claimant requested a hearing, and the claim was forwarded to the Office of Administrative Law Judges on October 23, 2003 (DX 202).

A formal hearing was scheduled for September 8, 2004. On August 24, 2004, the Claimant, through counsel, requested that the hearing be cancelled and that a decision be made on the record. There was no objection, and the Claimant's request for a decision on the record was granted by Order dated August 31, 2004.

II. Issues

The issues as listed on Form CM-1025 are:

1. Whether the claim was timely filed;

2. Whether the Claimant is a miner;

3. Whether the Claimant worked as a miner after December 31, 1969;

4. The number of years of coal mine employment by the Claimant;

5. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

6. Whether the Miner's pneumoconiosis arose out of coal mine employment;

7. Whether the Miner is totally disabled;

8. Whether the Miner's disability is due to pneumoconiosis;

9. The number of dependents for purposes of augmentation of benefits;

10. Whether the named Employer is the Responsible Operator; and,

11. The remaining issues set forth in paragraph 18, as well as the issues as to constitutionality of the Act and its regulations are preserved for appeal purposes.

III. Findings of Fact and Conclusions of Law

The Claimant, Dallas L. Taylor, was born on February 20, 1943 (DX 1). He completed the eighth grade (DX 184). The Claimant has one dependent for purposes of augmentation of benefits, his wife Ivalia, whom he married on April 30, 1964 (DX 1).

At the November 14, 2000, hearing, the Claimant testified that he began smoking at age 18 (1961), and that somewhere around 1999, he reduced his smoking to approximately one-half pack of cigarettes per day (DX 183 at 32). The Miner's smoking start date is corroborated by the physicians' reports. The Miner reported a history from 1961-1999 at a rate of 1½ packs per day (DX 178). The Miner reported to Dr. Dahhan a history from 1963-1996 at a rate of two packs per day (DX 178). The Miner reported to Dr. Baker a 30-year habit at two packs per day (DX 191). The Miner reported to all physicians that he reduced his smoking somewhere between 1996-1999 to approximately one-half pack per day. He was still smoking at that rate when Dr. Baker examined him in 2002. While the precise smoking history is unclear from the inconsistent evidence in the record, I find that all reports show a smoking history of at least 60 pack years of cigarettes and that the Miner continues to smoke at a rate of approximately one-half pack per day of cigarettes.

Coal Mine Employment

Section 725.101(a)(32)(ii) directs an adjudication officer to determine the beginning and ending dates of coal mine employment using any credible evidence. At the November 14, 2000, hearing before Judge Kane, the parties stipulated to 20.5 years of coal mine employment, ending in 1985 (DX 184; DX 183 at

9-10, 17, 22). No new evidence regarding coal mine employment has been submitted with the current request for modification. Upon review of the analysis made in the 1989 Decision and Order and Judge Kane's 2000 employment analysis, I find the prior stipulation is supported by the record and credit the Claimant with 20.5 years of coal mine employment.

The Claimant's last employment was in the Commonwealth of Kentucky; therefore, the law of the Sixth Circuit is controlling.

Miner

Although the Employer contests whether the Claimant is a Miner, it previously stipulated to 20.5 years of coal mine employment. Noting the Employer's concession, I find that the Claimant was a Miner within the meaning of the regulations.

Post-1969 Employment

To name a responsible operator, the Miner's coal mine employment must include at least one working day after December 31, 1969. Twenty C.F.R. §§ 725.492(a)(3) (2000) and 725.494(d) (2001); *Bethlehem Mines Corp v. Warmus*, 578 F.2d 59 (3rd Cir. 1978). The Employer previously stipulated that the Miner worked in coal mine employment until 1985. Review of the evidence supports the stipulation. I find that the Claimant worked at least one day in coal mine employment after December 31, 1969.

Timeliness

The Employer contests the issue of timeliness. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The Employer has submitted no evidence or argument to support its position and the record contains no evidence that the Claimant received the requisite notice more than three years prior to filing his claim for benefits. Therefore, I find that this claim was timely filed.

Responsible Operator

Section 725.493 provides that the employer with whom the miner had the most recent cumulative employment of not less than one year shall be considered the responsible operator. For purposes of § 725.493(a), one year of coal mine employment may be established by accumulating intermittent periods of coal mine employment. Thus, a named operator is the responsible operator where: (1) the operator is the Miner's most recent employer;

and, (2) the Miner's cumulative employment with the operator amounted to more than one year, even where the Claimant worked for a different employer in between his work with the operator. *Snedecker v. Island Creek Coal Co.,* 5 B.L.R. 1-91 (1982).

In the December 15, 1989, Decision and Order, Judge Roketenetz (citing to *Crabtree v. Bethlehem Steele Corp.*, 7 B.L.R. 1-354 (1984)), dismissed Loftis Coal Company as the Responsible Operator and held if benefits were later awarded the Trust Fund must assume liability for payment of benefits (DX 84 at 13). He based his finding on Social Security earnings showing that Sharondale Coal Company, not Loftis Coal Company, was the Miner's last coal mine employment of over one year (DX 84 at 12). The Director did not appeal those findings (DX 99, 125).

In *Crabtree*, the Board held that the Department of Labor must resolve the issue of responsible operator in preliminary proceedings or proceed against all putative responsible operators at every stage of adjudication. Under such an approach, the agency is not entitled to a second opportunity to identify another responsible operator. *Crabtree, supra*.

On remand, Judge Roketenetz issued denials on March 31, 1993 (DX 102), and again on July 26, 1995 (DX 119). At no time from 1989 through 1999 did the Director appeal or contest the assignment of the claim to the Trust Fund, nor did it seek to name an additional or new responsible operator. In 1999, 10 years after the original dismissal of Loftis Coal Company, Inc., the Director submitted a Motion to Remand for the naming of Sharondale Coal Company as a new responsible operator. The Director argued that as the claim was a request for modification under § 725.310, a mistake in determination of fact was made in not initially naming Sharondale Coal Company as responsible operator. Citing *Director, OWCP v. Oglebay Norton*, 877 F.2d 1300 (6th Cir. 1989), the Director moved for remand for the purpose of naming Sharondale Coal Company as Responsible Operator.

In *Director, OWCP v. Oglebay Norton*, a case decided by the Sixth Circuit subsequent to Judge Roketenetz's 1989 dismissal of Loftis Coal Company, the Court refused to apply *Crabtree* where no prejudice resulted from naming a second responsible operator, since under 20 C.F.R. § 725.412(a), an operator can be named "at any time during the processing of a claim" although it should be done "as soon after the filing of the claim as the evidence obtained permits." *Oglebay Norton*, 877 F.2d 1300 (6th Cir. 1989). *See also, Lewis v. Consolidation Coal Co.*, 15 B.L.R. 1-

37 (1990) and *Beckett v. Raven Smokeless Coal Co.*, 14 B.L.R. 1-43 (1990).

This case was remanded to the Director in 1999 and Sharondale Coal Company was named as putative Responsible Operator.

On July 18, 1999, this claim was transferred back to the Office of Administrative Law Judges for a hearing. The claim was assigned to Administrative Law Judge Joseph Kane. After a November 14, 2000, hearing, Judge Kane issued a July 30, 2001, Decision and Order finding that Sharondale Coal Company had been properly added as responsible operator. Judge Kane, citing *Oglebay Norton*, stated that "Sharondale has had a full opportunity to defend the claim. Sharondale has not alleged nor specified any prejudice to it due to its late joinder. For example, there is no showing of x-rays, etc., being unavailable to it for evaluation by its own physicians." (DX 184 at 7).

In 2002, the Sixth Circuit revisited the adding of a new responsible operator in *Kentland Elkhorn Coal Corp. v. Hall*, 287 F.3d 555 (6th Cir. 2002). In *Hall*, the Sixth Circuit supported the reasoning in *Crabtree*, stating that:

> In *Crabtree*, the Board refused to remand for further consideration of the operator issue because the Director had ample opportunity to develop evidence about the proper responsible operator and failed to do so. Further the claim had been adjudicated on the merits at the time the Board reviewed the ALJ's decision.

Hall, 287 F.3d at 567. The Court went on to state that:

> In *Oglebay*, this Court allowed the Director to identify a new responsible operator ten years after the filing of the initial claim. … This Court allowed this, in large part … because the new operator would have access to the evidence developed in the case and a chance to challenge the Claimant's entitlement to benefits, given that no hearing on the merits had yet taken place, the addition of a new operator would not prejudice the parties.

Id. at 568.

This case is distinguishable from *Oglebay* in several ways. First, unlike the operator in *Oglebay*, this case has already had a hearing on the merits and several decisions on the merits to

which Sharondale Corp. had no opportunity to participate. Second, the Director did not appeal for 10 years the assignment of the claim to the Trust Fund. Third, I find that both parties are prejudiced by the naming of Sharondale Corp. as Responsible Operator. Sharondale Corp. is now defending against a request for modification. That is, the newly named Employer is now forced to defend a Decision denying benefits in which it did not participate, and to show that no mistake of fact was made in a prior denial in which it was not a party. Similarly, by adding Sharondale Corp. as a party, the Claimant must now defend its request for modification against two parties (the Director and Sharondale Corp.) instead of one.

I find that Sharondale Corporation was improperly named by the Director as Responsible Operator and should be dismissed from this claim. Any liability for benefits will be paid by the Black Lung Benefits Trust Fund.

MEDICAL EVIDENCE

Chest X-rays[2]

Ex. No.	Date of of X-ray	Film Qual.	Physician/ Qualifications[3]	Interpretation
DX 178	10/28/85	1	Westerfield/B	0/0
	Comments: Scarring at right diaphragm.			
DX 178	10/28/85	1	West/B, BCR	Negative 0/0.
DX 178	10/28/85	1	Kendall/B, BCR	Negative 0/0.
DX 178	10/28/85	1	Poulos/B, BCR	Negative 0/0.

[2] By Order dated November 19, 2004, the record was held open until December 6, 2004, for submission of medical evidence. On December 28, 2004, the Carrier submitted a June 26, 2004, x-ray interpretation by Dr. Dennis H. Halbert. As the submission was untimely, the Carrier's late interpretation is not considered in this Decision and Order.

[3] The symbol "BCR" denotes a physician who has been certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2).

The symbol "B" denotes a physician who was an approved B reader at the time of the x-ray reading. A B reader is a physician who has demonstrated expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

DX 178	10/28/85	1	Halbert/B, BCR	0/0.

Comments: Some scarring in right base associated with the right diaphragm.

DX 178	4/3/86	3	Westerfield/B	0/0

Comments: Scarring at right base.

DX 178	4/3/86	1	West/B, BCR	0/0.
DX 178	4/3/86	1	Kendall/B, BCR	0/0.
DX 178	4/3/86	2	Poulos/B, BCR	0/0.
DX 178	4/3/86	2	Halbert/B, BCR	Negative 0/0.
DX 178	4/29/86	2	Westerfield/B	0/0

Comments: Scarring at right mid diaphragm.

DX 178	4/29/86	2	West/B, BCR	Negative 0/0.
DX 178	4/29/86	1	Kendall/B, BCR	Negative 0/0.
DX 178	4/29/86	2	Poulos/B, BCR	Negative 0/0.
DX 178	4/29/86	2	Halbert/B, BCR	Negative 0/0.
DX 146	4/24/92	-	Bofill (Hospital)	

Comments: Interstitial change and suggestion of COPD. Right hemidiaphragm eventration.

DX 146	2/21/94	-	Kim (Hospital)	

Comments: Mild chronic diffuse interstitial change with COPD. Tenting of right hemidiaphragm. Flattened diaphragm.

DX 146	9/22/94	-	Kim (Hospital)	

Comments: Flattened diaphragm. Triangle-shaped density in right lower chest without significant change from 2/15/94, could be tenting of hemidiaphragm. Slightly increased size in width of base from 1992; looks benign. Increased retrosternal space, may suggest COPD.

DX 146 10/18/95 - Stebner (Hospital)

Comments: Tenting of the right hemidiaphragm or scarring at the lung base. Nonspecific linear nodular pattern in both lungs with prominence of the hilar shadows, flattening of the diaphragms, and ill-defined soft tissue density in LLL. Chronic changes with COPD similar to 9-22-94.

DX 146 11/16/95 - Stebner (Hospital)

Comments: Diffuse interstitial linear nodular pattern in both lung fields compatible with some type of pneumoconiosis. COPD. Tenting of right hemidiaphragm.

DX 144	10/29/97	1	Rubenstein/B, BCR	1/0, q/t, all six zones.

Comments: Pleural thickening.

DX 145	10/29/97	2	Bassali/B, BCR	1/2,q/t, all six zones.

Comments: Right noncalcified diaphragmatic pleural plaque. Kerley B-lines in both lung bases.

DX 147	10/29/97	2	Sargent/B, BCR	0/1

Comments: mid and lower zones, no evidence of CWP. Smoking history? Deformity right diaphragm, unknown etiology.

DX 148	10/29/97	2	Barrett/B, BCR	0/0

Comments: Scarring RUL probably secondary to prior inflammation. Bullae. Emphysema.

DX 178	10/29/97	2	Westerfield/B	0/0

Comments: Generalized increase in bronchial markings suggests chronic bronchitis. Scarring at right mid diaphragm.

DX 178	10/29/97	2	West/B, BCR	0/0

Comments: Suspect mild COPD with increased pulmonary arterial pressures.

DX 178 10/29/97 1 Kendall/B, BCR 0/0.

Comments: Changes consistent with COPD.

DX 178 10/29/97 3 Poulos/B, BCR Negative 0/0.

DX 178 10/29/97 2 Halbert/B, BCR 0/0.

Comments: Scarring in right base associated with right diaphragm.

DX 168 3/2/98 1 Sundaram 1/1, p/q

Comments: upper zones and mid right zone. Pleural thickening.

DX 170 3/2/98 3 Sargent/B, BCR 0/0.

Comments: Smoking history? Lungs hyperinflated. Calcified aortic arch. Localized lung volume loss right base.

DX 173 3/1/99 3 Sargent/B, BCR

Comments: Bullae? Emphysema? Tuberculosis?-Active? Smoking history? Calcified aortic arch? Deformity right diaphragm? Etiology? LUL infiltrate, unknown etiology - active TB?

DX 178 3/1/99 1 Sundaram 1/1, p/q

Comments: Upper and mid zones. Pleural thickening and calcification. LUL scar.

DX 178 3/1/99 1 West/B, BCR 0/0

Comments: LUL infiltrate with bullae, may be chronic or active, an atypical pneumonia such as tuberculosis could be responsible. Suggestive underlying COPD.

DX 178 3/1/99 1 Kendall/B, BCR 0/0, LUL infiltrate.

DX 178 3/1/99 - Hall (Hospital)

Comments: Left upper lobe and superior pneumonitis which may represent tuberculosis, fungal infection or atypical pneumonia. Neoplasm cannot be excluded. The appearance favors tuberculosis.

DX 178	3/1/99	1	Poulos/B, BCR	0/0

Comments: LUL infiltrate which may be (2 readings) acute or chronic in nature. Bullae changes LUL and apex. Underlying granulomatous disease process in LUL, such as tuberculosis, should be a consideration.

DX 178	3/1/99	2	West/B, BCR	0/0

Comments: Bullous emphysema with bullae left apex. LUL infiltrate is worrisome for tuberculosis. Small nodular densities in both mid to lower lungs should be followed to exclude pulmonary nodules. Note: Resolved on later films.

DX 178	3/1/99	1	Halbert/B, BCR	0/0

Comments: Large infiltrate LUL. Large bullae, left apex. Some scarring right base associated with right diaphragm. Due to scarring in left lung, evaluation for pneumoconiosis based on right lung.

DX 178	3/1/99	1	Kendall/B, BCR	0/0. LUL interstitial infiltrate.
DX 178	5/26/99	1	Patel/B, BCR	1/0, t/s, 6 zones.

Comments: Mild COPD with upper zone bullous changes. Parenchymal scarring in LUL associated with disorganization of the pulmonary architecture.

DX 178	5/26/99	1	Poulos/B, BCR	0/0
DX 178	5/26/99	1	West/B, BCR	0/0

Comments: COPD with left apex bullae and interstitial scarring. Possible left significant pulmonary nodule.

DX 178	5/26/99	1	Halbert/B, BCR	0/0.

Comments: Because of the extensive scarring in left lung apex, evaluation for pneumoconiosis is based on the appearance of the right lung. Bullae.

DX 178	5/26/99	1	Kendall/B, BCR	0/0. LUL interstitial infiltrate.
DX 178	6/23/99	-	Hall (Hospital)	

Comments: Atelectasis is most likely in RUL, cannot exclude pneumonia however. Scarring and retraction in LUL with bullous emphysematous changes, cannot entirely exclude a neoplasm or indolent process.

DX 178	12/8/99	1	Fino/B	Completely negative.
DX 178	12/8/99	1	Poulos/B, BCR	Bullae left apex. 0/0.
DX 178	12/8/99	1	West/B, BCR	0/0

Comments: COPD with apical bullae and scarring. Possible neoplasm in LML.

DX 178	12/8/99	2	Halbert/B, BCR	0/0 right lung
DX 178	12/8/99	1	Kendall/B, BCR	0/0. LUL interstitial infiltrate.
DX 178	12/18/99	1	Dahhan/B	0/0 Emphysema
DX 178	12/18/99	3	Sargent/B, BCR	0/0.

Comments: Bullae Emphysema. Smoking history? Pulmonary arterial hypertension? Eventuation or herniation right hemidiaphragm?

DX 195	10/21/02	1	Baker, B	0/1
DX 196	10/21/02	1	Barrett, B, BCR	0/0
CX 1	06/26/04	1	DePonte/ B, BCR	1/1

Comments: COPD w/pleural thickening and post surgical change, likely unrelated to pneumoconiosis.

CT Scans

The Claimant underwent a CT scan on September 27, 1994, while hospitalized. Dr. J.H. Kim's impression was: "Previously seen triangle density in the right lower chest appears to be tenting right hemidiaphragm with fact. No definite mass is seen." (DX 146).

The Claimant underwent another CT scan while he was hospitalized on June 27, 1999. The impression by Dr. Dan Hall was:

> Calcified, less than 1 cm, lesion in the left upper lobe likely representing a granuloma. Neoplasm is much less likely. A small focus of airspace disease is present in the right middle lobe posteriorly and likely represents atelectasis. The lesion in the left upper lobe could be followed by serial chest x-rays to verify stability. (DX 178).

Pulmonary Function Studies

Date	Ex. No.	Age/Hgt.	FEV_1	FVC	FEV_1/ FVC	MVV	Coop/ Comp.
6/2/86	DX 160	43/66"	1.18	2.78	42.45%	- -	- -
	Post-bronchodilator		1.72	3.49	49.28%		

Validation: Dr. Nausherwan K. Burki, who is Board-certified in Internal and Pulmonary Medicine, found the above study to be valid (DX 160).

3/21/88	DX 161	45/66"	1.18	2.65	44.53%	- -	- -
	Post-bronchodilator		1.39	2.69	51.67%		
3/7/94	DX 162	51/66"	0.73	1.63	44.79%	- -	- -
	Post-bronchodilator		0.86	2.13	40.38%		
1/12/96	DX 163	53/66"	0.42	1.18	35.59%	- -	- -
	Post-bronchodilator		0.49	1.42	34.51%		

Validation: Dr. Burki also reviewed the March 21, 1988 (DX 161), the March 7, 1994 (DX 162), and the January 12, 1996 (DX 163), studies and opined that all three were invalid due to the lack of original tracings (DX 161, 162, 163). He also found the March 21, 1988, study invalid due to the variability in the curves indicating suboptimal effort (DX 161).

5/26/99	DX 178	56/64"	0.91	3.46	26%	39	Good
	Post-bronchodilator		1.02	3.43	30%	38	

05/26/03	CX 3	60/66"	0.55	2.05	25%	23	Good

Arterial Blood Gas Tests

Date	Physician	pCO_2	pO_2	Ex. No.
4/27/90	Hospital	36.3	74.3	DX 146
4/24/92	Hospital	40.6	69.6	DX 146
2/17/94	Hospital	71.7	60.6	DX 152

Validation: Dr. Burki found the above study to be invalid as the pCO_2 value was too high for the noted pO_2 on room air (DX 152).

9/22/94	Hospital	39.5	42.9	DX 153
9/23/94	Hospital	43.3	69.9	DX 146
10/19/95	Hospital	50.0	50.0	DX 154
11/16/95	Hospital	59.3 (on 2 liters of oxygen)	60.5	DX 155
11/17/95	Hospital	74.0 (on 4 liters of oxygen)	75.0	DX 156
11/12/96	Sundaram	58.4	63.8	DX 157
11/16/96	Sundaram	57.0	60.0	DX 158
12/13/97	Sundaram	47.7	60.3	DX 159
5/26/99	Rasmussen	49.0	57.0	DX 178
	After exercise	53.0	55.0	
12/8/99	Fino	51.2	61.7	DX 178
12/18/99	Dahhan	50.1	52.5	DX 178
	After exercise	46.0	54.5	

Hospital Records, Biopsy Reports, and Medical Examinations

The Claimant was hospitalized at Williamson Memorial Hospital from April 24-27, 1992, due to severe headache, blurred vision, shortness of breath and high blood pressure. Previous admissions were for acute asthmatic bronchitis. Dr. Maximo Tan attended to the Claimant, and gave discharge diagnoses of severe headache due to migraine; hypertension, uncontrolled; chronic

obstructive pulmonary disease ("COPD"); and low back pain (DX 146).

The Claimant was hospitalized at Williamson from February 16-20, 1994, due to bronchopneumonia. The discharge diagnoses by Dr. Tan were bilateral interstitial pneumonia, COPD, and history of hypertension (DX 146).

The Claimant was re-admitted from September 22-27, 1994, because of "severe shortness of breath, coughing and wheezing which he has been having for the past week and this has not been getting any better in spite of antibiotics that he has been taking at home." The medical history noted was prior "admissions to this hospital for the same problem of acute asthmatic bronchitis as well as pneumonia. The patient is a cigarette smoker in spite of advice to stop smoking." Dr. Tan was attending physician. Discharge diagnoses were acute asthmatic bronchitis, severe COPD, hypertension, and arthritis (DX 146).

The Claimant was hospitalized at Williamson from October 18-21, 1995. The attending physician was Dr. Rosario Nadorra. A chest x-ray showed chronic interstitial changes consistent with emphysema with no acute infiltrate identified. The discharge diagnoses were acute respiratory failure secondary to COPD with acute exacerbation, acute chronic low back strain, and hypertension (DX 146).

The Claimant was re-admitted from November 16-21, 1995. Admitting impression was COPD with acute exacerbation, rule out respiratory failure. Dr. Tan was the attending physician. A chest x-ray showed evidence of COPD and some interstitial lung disease. Discharge diagnoses were acute, severe bronchitis, with bronchospasm; advanced COPD; and, severe leukocytosis, due to infections (DX 146).

The Claimant was admitted to Williamson from November 12-16, 1996. Dr. Maan Younes was the attending physician. Discharge diagnoses were chronic obstructive pulmonary disease with acute exacerbation, hypertension, chronic low back pain, and anxiety disorder (DX 146).

The Claimant was hospitalized at Highlands Regional Medical Center from March 1-7, 1999, due to increasing shortness of breath, chest congestion, and respiratory distress without any improvement following medication. The attending physician was Dr. Raghu Sundaram. History included COPD and coal workers' pneumoconiosis, with no family history of tuberculosis. An x-ray showed left upper lobe and superior segment pneumonitis and

it was felt that tuberculosis needed to be ruled out. Discharge diagnoses were bronchopneumonia with respiratory distress, chronic obstructive pulmonary disease with exacerbation, coal workers' pneumoconiosis, arteriosclerotic heart disease, and rule out tuberculosis pending AFB cultures (DX 175, 178).

On April 28, 1999, Dr. Sundaram wrote that:

> This gentleman has been seen by me for several years, his first visit was on 01-31-96 and the most recent was a follow-up visit on 12-19-98. His chief complaint is a history of shortness of breath on limited activity, smothering at night time. He has a history of smoking, he continues to smoke approximately ten (10) cigarettes a day. He also has a long history of coal exposure. ...
>
> Mr. Taylor cannot walk a distance of one block or go up flight of steps. He cannot lift any weight beyond ten pounds or carry the same over a few feet. The prognosis for Mr. Taylor would be in my professional opinion 1. coal workers pneumoconiosis; 2. chronic obstructive pulmonary disease. His problems definitely lays [sic] from his long exposure to coal dust of 21½ years. Considering his physical and significant impaired status, pulmonary function studies, x-rays, and blood gases that I have received from Williamson Hospital, he would be unable to indulge in any gainful employment and as such he is permanently and totally disabled. He is 56 years of age, again Mr. Taylor's disability would be due to his underlying condition of coal workers pneumoconiosis.
>
> Patient is advised to continue his oxygen on 24 hour basis and multiple medications he is on and follow up at the office as needed.

(DX 168, 169, 178).

Dr. D.L. Rasmussen interviewed and examined the Claimant on May 26, 1999. The smoking history was 1½ packs of cigarettes per day from age 18 in 1961; currently one-half pack per day. Family history included a father with asthma, emphysema, and black lung. Examination revealed low diaphragms, increased percussion note, moderately to markedly reduced breath sounds, inspiratory and expiratory wheezing and rhonchi, and marked prolongation of the expiratory phase with forced respirations. An x-ray was read by Dr. Patel as positive for pneumoconiosis, 1/0. An electrocardiogram revealed sinus rhythm with moderate

premature atrial contractions and occasional premature ventricular contractions and P pulmonale. A pulmonary function study showed severe, irreversible obstructive insufficiency. An arterial blood gas test at rest was abnormal, with marked hypoxia and moderate hypercarbia during exercise. Dr. Rasmussen concluded that:

> These studies indicate very severe, totally disabling respiratory insufficiency with evidence of probable cor pulmonale and pulmonary hypertension as reflected by the early anaerobic threshold. Obviously this patient would be totally disabled for resuming his last regular coal mine job.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he has coal workers' pneumoconiosis which arose from his coal mine employment.
>
> There appear to be 3 risk factors for this patient's disabling respiratory insufficiency. He does have a history suggestive of hyperactive airways disease, which, in fact could make him more vulnerable to the adverse effects of both cigarette smoking and coal mine dust exposure, the other two risk factors for his impairment. His coal mine dust exposure must be considered a significant contributing factor to his totally disabling respiratory insufficiency.

(DX 178).

The Claimant was hospitalized from June 23-30, 1999, due to recurrent episodes of vomiting, dehydration, shortness of breath, extreme weakness, and tightness. The attending physician was Dr. Sundaram. History included positive PPD with previous hospitalizations with no evidence for active tuberculosis on the AFB smears and cultures; COPD; coal workers' pneumoconiosis; and, moderate anxiety. A chest x-ray showed atelectasis in the right middle lobe, the possibility of pneumonia considered, and bullous emphysematous changes in the left upper lobe. A bronchoscopy was obtained, with biopsies of the left upper and right middle lobes. The specimens consisted of benign bronchial epithelium and pulmonary parenchyma, with the right lung showing a slight increase in anthracotic pigment beneath the bronchial mucosa. A CT scan was also obtained. The discharge diagnoses were bronchopneumonia, acute gastritis with dehydration, chronic obstructive pulmonary disease, coal

workers' pneumoconiosis, and hypokalemia resolved with therapy. (DX 178).

On December 1, 1999, Dr. Sundaram wrote that:

> I have been treating Mr. Larry Taylor for several years now for shortness of breath due to COPD and Black Lung Disease. He has undergone many tests in the past and also recently, which have put much strain on his body. His condition is so severe that he should not undergo any more testing due to the stress that it creates on his body.

(DX 178).

Dr. Raghu Sundaram, who lists no medical specialty credentials, performed a bronchoscopy on the Claimant on December 28, 2002 (DX 190). He made a postoperative diagnosis of "endobronchial mass lesions, rule out cancer, rule out TB, Rule out secretions." No diagnosis of pneumoconiosis was made.

On December 7, 1999, Dr. P. Raphael Caffrey reviewed the biopsy report of Dr. Braswell (hospital, June 30, 1999) at the Employer's request, and stated that:

> The criteria for a pathologist to make a diagnosis of CWP was spelled out in the "Pathology Standards for Coal Worker's Pneumoconiosis" published in the Archives of Pathology and Laboratory Medicine, July 1979. Anthracotic pigment alone is not synonymous with CWP. The lesion of simple CWP consists of anthracotic pigment plus reticulin and usually focal emphysema.

Dr. Caffrey is Board-certified in Anatomical and Clinical Pathology (DX 178).

Dr. Gregory J. Fino, who is Board-certified in Internal and Pulmonary Medicine, examined the Claimant on December 8, 1999, at the request of the Employer. Examination of the chest revealed an increased AP diameter with a prolongation of the expiratory phase and wheezes on a forced expiration. An x-ray was interpreted as negative for pneumoconiosis. A pulmonary function study was not obtained due to the Claimant's treating physician's advice. An arterial blood gas test revealed moderate hypoxia and moderate hypercarbia. Dr. Fino also reviewed additional medical records. He concluded that the Claimant was totally disabled due to severe chronic obstructive pulmonary disease due to smoking. He concluded that the

Claimant did not have an occupationally acquired pulmonary condition as a result of coal mine dust exposure because:

> 1. The majority of chest x-ray readings are negative for pneumoconiosis.
>
> 2. My reading of the chest x-ray is negative for pneumoconiosis.
>
> 3. The spirometric evaluations that have been performed show an obstructive ventilatory abnormality based on the reduction in the FEV_1/FVC ratio. This obstructive ventilatory abnormality has occurred in the absence of any interstitial abnormality. In addition, the obstruction shows involvement in the small airways. Large airway flow is measured by the FEV_1 and FEV_1/FVC ratio. Small airway flow is measured by the FEF 25-75. On a proportional basis, the small airway flow is more reduced than the large airway flow. This type of finding is not consistent with a coal dust related condition but is consistent with conditions such as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. Minimal obstructive lung disease has been described in working coal miners and has been called industrial bronchitis. This condition is characterized by cough and mucous production plus minimal decreases in the FEV_1 in some miners. Industrial bronchitis resolves within six months of leaving the mines. Obstructive lung disease may also arise from coal workers' pneumoconiosis when significant fibrosis is present. The fibrosis results in the obstruction. In this case, although obstruction can be seen in coal workers' pneumoconiosis, the obstruction is unrelated to coal mine dust exposure.
>
> 4. There is significant hypercarbia. This is consistent with smoking; it is not consistent with clinical or legal pneumoconiosis.

Dr. Fino added that:

> Even if industrial bronchitis due to coal mine employment contributed to the obstruction, the loss in FEV_1 would be in the 200 cc range. If we gave back to him that amount of FEV_1, this man would still be disabled. This medical estimate of loss in FEV_1 in working miners was summarized in the 1995 NIOSH

> document. Although a statistical drop in the FEV_1 was noted in working miners, that drop was not clinically significant. This man would be as disabled had he never stepped foot in the mines.

(DX 178).

Dr. Fino performed a records review on December 29, 1999. His conclusions remained the same. Additionally, Dr. Fino summarized and commented on the medical literature. The studies showed the following average losses in FEV_1 in the noted countries: 108cc (UK), not significant (USA), 65cc (UK), 147cc (USA), 146cc (UK), 450cc (UK), 196cc (UK), no effect (USA), 113cc (USA), 495cc (USA), 1.8cc-531cc (USA), 2536cc (France), 108cc (USA), and 1440cc (Italy). Dr. Fino stated that:

> As an initial matter, the effect on FEV_1 needs to be defined. All of the estimates noted above … represent average losses of FEV_1 assuming 45 years of working underground in the mines with a dust concentration of 2 mgm/m^3. This was calculated in order to compare and contrast the various studies. An average loss of FEV_1 means that 50% of the miners will have losses in excess of the average and 50% will have losses smaller than the average. When applying this to an individual miner, one might as well flip a coin to make the decision whether the loss is greater than, or less than, the average. In other words, these articles merely reflect the law of probability, not statistical analysis or clinically significant findings.
>
> In addition, all of the studies that measured an average FEV_1 loss are flawed because of selection bias. The results cannot be generalized to all miners. All of the authors discuss the problems with selection bias and the limitations of the study. ...

Later in his report, Dr. Fino stated that:

> The studies which attempted to show a decrease in the FEV_1 due to coal mine dust inhalation did not carefully control for, or consider other potential risk factors for the decline in FEV_1 apart from the usual factors such as aging, smoking and dust exposure measurements.
>
> Banks (3) noted that there is a "statistically significant relationship between mean FEV_1 decline and dust exposure." He refers to a number of "other"

potential factors for the decline in the FEV_1 aside from smoking, age and dust:

1. Host susceptibility factors
2. Familial history of atopy
3. Childhood illnesses
4. Obesity and excessive weight gain
5. Intercurrent respiratory infection
6. Mine effect
7. Environment exposures, and
8. Socioeconomic status

He goes on to state 'attributing this effect to dust alone in any individual worker may not be reasonable unless specific information regarding the overall health of each worker is available. An assessment of the individual is necessary to understand the relationship between dust exposure, lung function decline and other medical problems.'

Dr. Fino additionally stated that:

> There is no doubt that some miners do have clinically significant obstruction as a result of coal mine dust inhalation. This actually is expected in most cases of severe fibrosis where a combined obstructive and restrictive defect is present. However, there is no evidence that there is a clinically significant reduction in the FEV_1 as a result of chronic obstructive lung disease due to coal mine dust inhalation. None of the studies show that.

The doctor further stated:

> The pathological description of coal workers' pneumoconiosis includes an entity called focal emphysema associated with the lesion of coal workers' pneumoconiosis. Some feel that this is centriacinar emphysema. The issue, however, is whether or not simple coal workers' pneumoconiosis or coal mine dust inhalation alone causes <u>clinically significant</u> emphysema. Whether or not it is referred to as focal or centriacinar is moot. The presence of emphysema in the lungs does not automatically imply respiratory impairment. The following does not pertain to complicated pneumoconiosis. It is well known that this condition may result in clinically significant emphysema and respiratory impairment.

A review of the literature provides the following conclusions:

> 1. There has been confusion in the literature regarding the distinction between focal emphysema and centrilobular emphysema since both affect the same portion of the lung acinus. However, regardless of this debate, clinical impairment as a result of emphysema is the gold standard when evaluating a miner's pulmonary status.
>
> 2. The amount of emphysema in the lungs of miners increases with the severity of simple coal workers' pneumoconiosis. However, this is not true in simple silicosis.
>
> 3. Increasing severity of simple coal workers' pneumoconiosis (by radiograph or autopsy) is not correlated with a worsening of lung function.

As to particular studies, Dr. Fino commented that:

Dr. Wright and others published a 'State of the Art' review on 'Diseases of the Small Airways' (17). He discussed the association of mineral dusts and emphysema and commented that emphysema (pathologic) has been described in coal workers' pneumoconiosis. 'The lesions in coal workers have been termed focal emphysema. They appear as enlarged air spaces in the central portion of the lobule, and they bear a considerable resemblance to centrilobular emphysema induced by cigarette smoke, albeit the lesions in coal workers never appear to achieve the same severity as may be seen with smoke.'

Dr. Gordon L. Snider also published a state-of-the-art review on emphysema (20, 21). He acknowledged that emphysema is a condition of the lung characterized by 'enlargement of the respiratory air spaces' and described a number of different types of air space enlargement. In proximal acinar emphysema, the emphysema or enlargement of the air spaces begins in the respiratory bronchioles. He identifies two forms of proximal acinar emphysema. The first form is the 'focal emphysema of simple coal workers' pneumoconiosis' and the second form is 'centrilobular emphysema.' He distinguishes the centrilobular

> emphysema by stating that it is the 'dominant form of emphysema in smokers.'

(DX 178).

Dr. Fino was deposed on April 12, 2000. He repeated his findings. As to the difference in x-ray readings, Dr. Fino said that he disagreed with the positive readings (DX 178).

Dr. Abdul K. Dahhan examined the Claimant on December 18, 1999, at the request of the Employer. The smoking history was two packs of cigarettes per day beginning at age 20, cutting back to one-half pack per day three years ago, and quitting altogether three months ago. Examination of the chest revealed an increased AP diameter with hyperresonancy to percussion. Peripheral cyanosis was noted. An electrocardiogram showed regular sinus rhythm with a pattern of left anterior hemiblock. A pulmonary function study was declined on doctor's advice. An arterial blood gas test was obtained at rest and with exercise, and the carboxyhemoglobin level was 6.4%. An x-ray was interpreted as negative for pneumoconiosis. Dr. Dahhan concluded that:

> 1. There is insufficient objective data to justify the diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest, the treatment program according to Mr. Taylor's family physician and negative x-ray reading for pneumoconiosis.
>
> 2. Mr. Taylor has advanced chronic obstructive lung disease of the variety of chronic bronchitis and emphysema.
>
> 3. Due to Mr. Taylor's decline of the pulmonary function studies direct measurement of his true ventilatory capacity is not possible. However, I do not believe that he retains the respiratory capacity to return to his previous coal mining work or job of comparable physical demand.
>
> 4. Mr. Taylor's pulmonary disability did not result from coal dust exposure or occupational pneumoconiosis. He has not had any exposure to coal dust since 1985, a duration of absence sufficient to cause cessation of any industrial bronchitis that he may have had. Also, his family physician is treating him with multiple bronchodilators, including steroids and anti-asthma medication indicating that he believes

that his condition is responsive to such therapy. These findings are inconsistent with the permanent adverse affects of coal dust on the respiratory system.

5. Mr. Taylor's obstructive airway disease has resulted from his 60+ pack years of smoking, an amount sufficient to cause the development of a disabling obstructive ventilatory defect in a susceptible individual. His carboxyhemoglobin level when I examined him was consistent with an individual smoking two packs per day, contradicting his statement that he had stopped smoking.

6. Mr. Taylor's pulmonary disability was not a result of coal dust exposure or coal workers' pneumoconiosis and I conclude that it would have developed at the same time and in the same manner regardless of whether or not he had ever worked in the coal mining industry or was exposed to coal dust.

7. Mr. Taylor has low back pain, essential hypertension and anxiety with depression. All are conditions of the general public at large and are not caused by, contributed to or aggravated by coal dust exposure or coal workers' pneumoconiosis.

Dr. Dahhan is Board-certified in Internal and Pulmonary Medicine (DX 178).

Dr. Ben V. Branscomb, a Board-certified Internist and B reader, reviewed the medical evidence on behalf of the Employer and issued a report on June 26, 2000. As to x-rays and CT scans, Dr. Branscomb stated that:

Nearly everyone commented on the tenting or scarring at the right diaphragm beginning in 1985. Toward the more recent dates there were descriptions of pneumonias which then improved or resolved. One such pneumonia resulted in a left upper lobe scar.

There is an overwhelming preponderance of negative readings for pneumoconiosis, including the opinions of many highly experienced "B" readers. Nonspecific changes or COPD were noted by some persons. There were two CT scans. In neither of these were changes identified suggesting CWP. Dr. Stebner described nonspecific linear and nodular changes and [sic] his

interpretation of the CT of 09/27/94 or 09/28/94. His conclusion was that these were changes of COPD.

Dr. Branscomb's conclusion was that:

> There is no evidence of pneumoconiosis.
>
> Mr. Taylor was totally disabled to perform hard labor including coal mining. This was the result of chronic asthmatic bronchitis. This in turn was caused by a very severe smoking addiction plus a history of severe asthma and a positive family history of asthma and allergies. All his pulmonary problems were conditions of the general public and neither caused nor in any way aggravated or adversely influenced by coal dust exposure. He has no disability arising from his occupation as a coal miner with the exception of low back injuries.
>
> If I assume that Mr. Taylor has simple pneumoconiosis it would still be my conclusion that such pneumoconiosis neither caused his disabling obstructive pulmonary disease nor in any way aggravated or contributed to it.

(EX 1).

Dr. Branscomb was deposed on September 26, 2000. He testified that:

> It is well known that the combination of smoking in a person who has asthma is the most important predisposing risk factor for the production of chronic obstructive pulmonary disease. There's a name for that. It's called the Dutch Hypotheses because in the Netherlands they first realized that since everybody with asthma does not become totally disabled, who does? The answer is those people who both smoke and have asthma are much more likely to become disabled.
>
> The ongoing clinical course of the pulmonary disease in this gentleman was one of attacks of wheezing, attacks that produced acute sudden and severe worsening of the breathing. That is the pattern of asthma. When persons who have asthma either have it for a long time and fairly severely, and certainly if they smoked, they often have pronounced bronchitic symptoms as well. Now that justifies calling the

> diagnosis asthmatic bronchitis or bronchitis with asthma rather than simply pure asthma.

(EX 2).

Dr. Glen Baker, who lists no medical specialty credentials, examined the Claimant on October 21, 2002 (DX 191). Based on symptomatology (sputum, wheezing, dyspnea, cough, chest pain, ankle edema), employment history (23 years, underground), individual and family histories (prior back injury, ulcers), smoking history (30 years, 2 packs per day, currently ½ pack per day), physical examination (normal), chest x-ray (0/1), pulmonary function study (refused by Claimant), arterial blood gas study (moderate severe resting hypoxemia), and an EKG (normal), Dr. Baker diagnosed: 1) moderately severe resting arterial hypoxemia based upon pO_2 reading; 2) chronic bronchitis based on a history of cough, sputum production, and wheezing; 3) probable COPD with bilateral inspiratory/expiratory wheezing by history; and, 4) chest pain by history. He opined that all conditions were caused by a combination of cigarette smoking and coal dust exposure. He later opined that the Miner does not have an occupational lung disease caused by coal mine employment. Dr. Baker opined that it was difficult to assess total disability "with lack of pulmonary function test. However pO_2 of 59 and patient having tight bilateral inspiratory/expiratory wheezing, I would estimate patient has at least a moderate obstructive defect, if not severe." He opined that the Miner no longer retains the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment, based on arterial blood gas readings and bilateral inspiratory/expiratory wheezing.

Dr. Westerfield, a Board-certified Internist, Pulmonologist, Medical Examiner, Sleep Medicine Specialist, and B reader, performed a November 3, 2003, records review at the request of the Employer (EX 1). He concluded that x-ray evidence was overwhelmingly negative for coal workers' pneumoconiosis. He opined that the Miner suffers from chronic obstructive pulmonary disease as a result of asthma and cigarette smoking. He noted a history of asthma and continued cigarette smoking and opined that in the absence of positive x-ray evidence, "it is highly unlikely that this deterioration of lung function would be related to his prior history of coal mining." He diagnosed no pneumoconiosis. He further opined that pulmonary function and arterial blood gas testing showed that Mr. Taylor is totally disabled from respiratory disease. "His pulmonary impairment is severe and it is my opinion that the cause of this impairment is chronic obstructive pulmonary disease due to cigarette smoking and asthma. Mr. Taylor

demonstrates progressive decline in his respiratory function. It is my opinion that Mr. Taylor's pulmonary impairment has not been caused by, aggravated by, or significantly contributed to by pneumoconiosis or his exposure to dust during coal mine employment."

Dr. B.T. Westerfield reviewed the medical records on behalf of the Employer and issued a report on December 2, 1999. He concluded that, based on his x-ray readings and the majority of negative readings, the Claimant does not have coal workers' pneumoconiosis. He concluded, however, that the Claimant was totally disabled from pulmonary disease. He described it as "severe Chronic Obstructive Pulmonary Disease with both severe reduction in flow rates on spirometry and hypoxemia (low oxygen) with hypercarbia (elevated CO_2) on arterial blood gas," and related it to cigarette smoking. He stated that he did "not find any evidence that respiratory impairment in Mr. Taylor is related to Coal Workers' Pneumoconiosis." (DX 178).

Discussion and Applicable Law

Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.[4]

Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by 20 C.F.R. § 725.310, provides that upon a miner's own initiative, or upon the request of any party on the grounds of a change in condition or because of a mistake in a determination of fact, the fact-finder may, at any time prior to one year after the date of the last payment of benefits or any time before one year after the denial of a claim, reconsider the terms of an award of a denial of benefits. Section 725.310(a). Because the Claimant's request for modification was made within one year after the denial of his claim, the Claimant's motion is timely and will be considered under the relevant regulatory provisions found at § 725.310.

In deciding whether a mistake in fact has occurred, the United States Supreme Court stated that the Administrative Law

[4] Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of § 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). Furthermore, the Sixth Circuit Court of Appeals, under whose appellate jurisdiction this case arises, has held that a modification petition need not specify any factual errors or change in conditions, and indeed, the Claimant may merely allege that the ultimate fact - total disability due to pneumoconiosis - was wrongly decided and request that the record be reviewed on that basis. The "adjudicator has the authority, if not the duty, to reconsider all the evidence for any mistake of fact or change in conditions." *Consolidation Coal Co. v. Director, OWCP*, 27 F.3d 226 (6th Cir. 1994).

In determining whether a change in condition has occurred requiring modification of the prior denial, the Board has similarly stated that:

> … the administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Kingery v. Hunt Branch Coal Co., 19 B.L.R. 1-6 (1994). Furthermore,

> if the newly submitted evidence is sufficient to establish modification …, the administrative law judge must consider all of the evidence of record to determine whether the Claimant has established entitlement to benefits on the merits of the claim.

Kovac v. BCNR Mining Corp., 14 B.L.R. 1-156 (1990), modified on recon., 16 B.L.R. 1-71 (1992).

The Miner's claim was denied on second remand by Judge Roketenetz on July 26, 1995, because the evidence was found insufficient to establish the existence of pneumoconiosis. The issue of total disability was not reached (DX 119). Thus, the newly submitted evidence will now be reviewed in conjunction with the prior evidence to determine whether the Claimant can now show he suffers from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, whether he is totally disabled, and whether he is totally disabled due to pneumoconiosis. The entire record will be reviewed to determine

whether a mistake in a determination of fact occurred in the prior denial.

In order to establish entitlement to benefits in a living miner's claim under 20 C.F.R. § 718, the Claimant must establish that he suffers from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. *See* 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6th Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence.

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp., Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Zeigler Coal Co. v. Kelley*, 112 F.3d 839, 842-43 (7th Cir. 1997); *Bethenergy Mines, Inc. v. Cunningham*, Case No. 03-1561 (4th Cir., July 20, 2004) (unpub.).

An independent assessment of x-ray evidence submitted since the July 31, 1995, denial must be performed and considered in conjunction with the previously submitted evidence to determine if the weight of the new x-ray evidence is sufficient to establish the existence of pneumoconiosis under § 718.202(a)(1).

The x-ray evidence consists of 56 interpretations of 17 x-rays. B readers made eight interpretations. Thirty-nine interpretations were made by Board-certified Radiologists who are also B readers. Physicians with no known expertise in the reading of x-rays made nine interpretations.

The October 18, 1995, x-ray was interpreted by Dr. Stebner, who lists no radiological specialty credentials, as showing nonspecific linear nodular patterns. He did not elaborate as to whether the nodular patterns were consistent with pneumoconiosis. A medical opinion may be given little weight if it is vague. *Island Creek Coal Co. v. Holdeman*, 202 F.3d 873 (6th Cir. 2000). Dr. Stebner's vague reference to nodular patterns in the Miner's lungs does not support or refute a pneumoconiosis diagnosis. As I cannot determine the actual diagnosis made, I give this x-ray interpretation no probative weight.

The November 16, 1995, x-ray was read as positive by Dr. Stebner, who lists no radiological specialty credentials. I find the November 16, 1995, x-ray to be positive for pneumoconiosis but afford it only some weight due to Dr. Stebner's lack of radiographic specialty credentials.

The October 29, 1997, x-ray was read as negative by Drs. Sargent, Barrett, West, Kendall, Poulos, and Halbert, all of whom are B readers and Board-certified Radiologists. The film was read as positive by Drs. Rubenstein and Bassali, who are also B readers and Board-certified Radiologists. I give greater weight to the six dually certified negative readings over the two dually certified positive readings and find that the October 29, 1997, film is negative for pneumoconiosis.

The March 2, 1998, x-ray film was read as negative by Dr. Sargent, a B reader and Board-certified Radiologist, and as positive by Dr. Sundaram, who lists no radiological specialty credentials. I give greater weight the dually certified reading of Dr. Sargent and find that the March 2, 1998, x-ray film is negative for pneumoconiosis.

The March 1, 1999, x-ray was read as negative by Drs. Sargent, West, Kendall, Poulos, and Halbert, all of whom are B readers and Board-certified Radiologists, and as negative by Dr. Hall, who lists no specialty credentials in the interpretation of x-rays. The film was read as positive by Dr. Sundaram, who lists no radiological specialty credentials. I give greater weight to the five negative readings by dually certified physicians and find the March 1, 1999, x-ray evidence to be negative for pneumoconiosis.

The May 26, 1999, x-ray was read as negative by Drs. Poulos, West, Halbert, and Kendall, all dually certified physicians, and as positive by Dr. Patel, a B reader and Board-certified Radiologist. I give greater weight to the four dually certified negative readings over the one positive dually certified interpretation, and find that the May 26, 1999, x-ray evidence is negative for pneumoconiosis.

The June 23, 1999, x-ray was read as negative by Dr. Hall, who lists no radiological specialty credentials. I find the June 23, 1999, x-ray evidence to be negative but afford this interpretation limited weight due to Dr. Hall's lack of radiographic specialty credentials.

The December 8, 1999, December 18, 1999, and October 21, 2002, x-rays were read as negative by all reviewing physicians.

The June 24, 2002, x-ray was read as positive by Dr. DePonte, a B reader and Board-certified Radiologist.

The newly submitted evidence contains eight negative x-ray films and two positive x-ray films. It includes 24 negative interpretations and three positive interpretations by dually certified physicians. I find that the existence of pneumoconiosis has not been established through newly submitted evidence under 20 C.F.R. § 718.202(a)(1). The previously submitted x-ray evidence was overwhelmingly negative.

Under § 718.202(a)(2), pneumoconiosis can be found through positive biopsy or autopsy results. A bronchoscopy and biopsy were performed on the Claimant during hospitalization from June 23-30, 1999 (DX 178). Dr. Sundaram noted a slight increase in anthracotic pigment, and he diagnosed bronchopneumonia, acute gastritis, chronic obstructive pulmonary disease, coal workers' pneumoconiosis, and hypokalemia. He did not explain how he reached those diagnoses. A medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *See Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). Dr. Sundaram offers no explanation as to how the biopsies obtained support the diagnoses made. I afford his opinion little weight.

Dr. Caffrey, a Board-certified Anatomical and Clinical Pathologist, reviewed the June 30, 1999, biopsy report and opined that anthracotic pigment alone is not synonymous with coal workers' pneumoconiosis. According to the "Pathology Standards for Coal Workers' Pneumoconiosis," published in the *Archives of Pathology and Laboratory Medicine*, July 1979, the

lesions of simple coal workers' pneumoconiosis consist of anthracotic pigment plus reticulin and usually focal emphysema. He diagnosed no coal workers' through biopsy evidence. Dr. Caffrey's opinion is well reasoned. He bases his opinion on objective data, the biopsy, and supports his opinion with medical literature. Noting Dr. Caffrey's superior credentials, I give his opinion substantial weight.

I find that newly submitted biopsy evidence does not support the existence of pneumoconiosis under § 718.202(a)(2).

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis. Section 718.201(a).

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6th Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *See Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

The Claimant was hospitalized from October 18-21, 1995, November 16-21, 1995, and November 12-16, 1996 (*See* DX 146). No physician diagnosed clinical pneumoconiosis. While all

physicians noted COPD, none tied the disease to coal mine employment.

The Claimant was hospitalized from March 1-7, 1999 (DX 175, 178). Dr. Sundaram noted a "history" of coal workers' pneumoconiosis. He issued a discharge summary diagnosing coal workers' pneumoconiosis based on the Claimant's "physical and significant impaired status, pulmonary function studies, x-rays, and blood gases that I have received from Williamson Hospital…." Dr. Sundaram does not document which testing he is referring to, nor does he state how those tests support a finding of coal workers' pneumoconiosis. A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984). I am unable to determine the specific data relied on by Dr. Sundaram or how that data would support his conclusions. Noting the lack of documentation in his report and Dr. Sundaram's lack of pulmonary specialty credentials, I give his opinion less weight.

Dr. D.L. Rasmussen, who presents no medical specialty credentials, examined that Claimant on May 26, 1999 (DX 178). He opined that the Claimant has a disabling respiratory insufficiency. After noting physical examination findings showing distress, and abnormal pulmonary function and arterial blood gas testing, he opined that:

> There appear to be 3 risk factors for this patient's disabling respiratory insufficiency. He does have a history suggestive of hyperactive airways disease, which in fact, could make him more vulnerable to the adverse effects of both cigarette smoking and coal mine dust exposure, the other two risk factors for his impairment.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he has coal workers' pneumoconiosis which arose from his coal mine employment.

Dr. Rasmussen's opinion is equivocal and not well reasoned. A physician's opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also, Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Dr. Rasmussen suggests that the Miner has

hyperactive airways disease and that such a condition "could" be aggravated by coal dust exposure. Noting Dr. Rasmussen's lack of pulmonary credentials and his equivocal diagnosis, I give less weight to his opinion.

Dr. Westerfield performed two record reviews on behalf of the Employer and diagnosed severe chronic obstructive pulmonary disease caused by asthma and cigarette smoking. He based his diagnosis on abnormal pulmonary function and arterial blood gas testing. He based his cigarette smoking etiology on negative x-rays indicating no coal dust-related fibrosis to cause or aggravate the abnormal pulmonary function observed. Dr. Westerfield's opinion is well reasoned. He based his diagnosis on objective data and then supported his smoking etiology through negative x-ray evidence. Noting the documentation of his opinion and his superior credentials, I give substantial weight to Dr. Westerfield's opinion.

Dr. Fino, a Board-certified Internist, Pulmonologist, and B reader, opined that the Miner did not have an occupationally acquired pulmonary condition as a result of coal mine dust exposure. He based his opinion on a majority of negative x-ray evidence, his own personal x-ray interpretation, pulmonary abnormality in the absence of any interstitial abnormality, and recorded hypercarbia, which is consistent with smoking but inconsistent with clinical or legal pneumoconiosis. He then dedicated several pages of his reports to discussing specific medical literature which supported his diagnosis. Dr. Fino based his opinion on objective data, supported his opinion with specific readings, and further explained through medical literature how the readings obtained supported his diagnosis. Noting Dr. Fino's superior credentials, I give his opinion substantial weight.

Dr. Dahhan, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant and opined that there was insufficient objective evidence to diagnose coal workers' pneumoconiosis. He based his opinion on negative x-ray evidence, the obstructive abnormalities on clinical evaluation of the chest, and the treatment program of Mr. Taylor's family physician. Dr. Dahhan noted that the Miner was continuing treatment with multiple bronchodilators, including steroids and anti-asthma medication, which indicated that Mr. Taylor's condition is responsive to such therapy. In his opinion, a positive response to bronchodilators is inconsistent with the permanent adverse affects of coal dust on the respiratory system. He opined that Mr. Taylor has advanced chronic obstructive pulmonary disease due to smoking. He based his smoking etiology on a carboxyhemoglobin level at examination

showing a current smoking habit of two packs per day of cigarettes when the Claimant stated he had quit smoking.

Dr. Dahhan's opinion is well reasoned. He utilized objective evidence to show that the Miner did not suffer from a coal dust-related condition, and then used further testing to demonstrate that the Miner's pulmonary abnormalities were caused by a heavy, continued cigarette smoking habit. Noting Dr. Dahhan's superior credentials, I give his opinion substantial weight.

Dr. Branscomb, a Board-certified Internist and B reader, performed a records review and opined that x-ray and CT scan evidence was predominately negative for pneumoconiosis. He noted abnormal pulmonary function and arterial blood gas testing and diagnosed chronic asthmatic bronchitis, due to severe heavy smoking addiction and a history of severe asthma. He cited medical literature describing the debilitating effects of asthma combined with cigarette smoking. He described the symptoms normally related with asthma and positively compared them to the Claimant's ongoing symptoms. Dr. Branscomb used the objective evidence and medical literature to support his diagnosis. Noting his superior credentials, I give his opinion great weight.

The Claimant underwent CT scans on September 27, 1994, and June 27, 1999, performed by Dr. J.H. Kim, who lists no radiographic specialty credentials (DX 146). Neither was diagnosed as positive for pneumoconiosis. The Department of Labor has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). Therefore, a CT scan, while arguably the most sophisticated and sensitive test available, must still be measured and weighed based upon the radiological qualifications of the reviewing physician. *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F.3d 885 (7th Cir. 2002). Dr. Kim presents no specialty credentials in the interpretation of CT scans. I find the CT scan evidence to be negative, but afford it only some weight.

Dr. Baker examined the Claimant and diagnosed hypoxemia based upon arterial blood gas testing; chronic bronchitis based upon a history of cough, sputum production and wheezing; and, COPD by history. He opined that all conditions were caused by a combination of cigarette smoking and coal dust exposure. He later opined that the Miner does not have an occupational lung disease caused by coal mine employment. A report may be given little weight where it is internally inconsistent and

inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (*en banc* on recon.). Dr. Baker fails to explain how all conditions are caused by a combination of cigarette smoking and coal dust exposure and yet the Miner does not suffer from an occupational lung disease caused by coal mine employment. Dr. Baker's opinion is internally inconsistent and unreasoned. His COPD diagnosis is based on "history" and is not supported by any documentation or testing. His chronic bronchitis diagnosis is based on a history of symptoms self-reported by the Miner. As such, it is based on subjective, not objective evidence. Noting the irregularities in his report and Dr. Baker's lack of pulmonary credentials, I give his opinion less weight.

Drs. Westerfield, Fino, and Dahhan, all Pulmonary Specialists, and Dr. Branscomb, a Board-certified Internist, provide well-reasoned opinions that the Miner does not suffer from clinical or legal pneumoconiosis. This finding is supported by hospitalization records which do not diagnose pneumoconiosis and by negative CT scan evidence. The contrary opinions of Drs. Sundaram, Baker, and Rasmussen, who list no pulmonary credentials, are outweighed by the more highly qualified physicians with better-reasoned opinions listed above. I find that newly submitted evidence does not establish pneumoconiosis under § 718.202(a)(4).

The newly submitted medical evidence, reviewed in conjunction with the prior medical evidence, does not established a change in conditions on the issue of pneumoconiosis. Review of all record evidence shows no mistake in determination of fact on the issue of pneumoconiosis. Pneumoconiosis is not established under § 718.202.

Causal Connection between Pneumoconiosis and Coal Mine Work

Because the Claimant has not established the existence of pneumoconiosis, the question of whether it is caused by his coal mine employment is moot. The evidence necessarily fails to establish this element of the claim.

Total Disability

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i) and (ii). The Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *See, e.g., Jewell Smokeless Coal*

Corp. v. Street, 42 F.3d 241 (4th Cir. 1994). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no physician reviewing the record biopsy evidence diagnosed massive lesions in the Miner's lungs.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 test results are divided by the FVC test results.

The newly submitted record contains four pulmonary function studies. The fact-finder must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). Dr. Burki reviewed the March 7, 1994, and the January 12, 1996, pulmonary function tests and opined that they did not meet the quality guidelines due to lack of original tracings. Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). Because these tests do not conform to the quality guidelines, I give them no probative weight on the issue of total disability. The May 26, 1999, and the May 26, 2003, pulmonary function tests produced qualifying readings. I find that newly submitted pulmonary function evidence supports total disability.

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The newly submitted record contains 14 arterial blood gas studies. Dr. Burki opined that the February 17, 1994, arterial blood gas test was invalid as the pCO_2 reading was too high for the noted pO_2 on room air (DX 152). I find the February 17, 1994, arterial blood gas study to be invalid. Of the remaining 13 tests, four produced nonqualifying readings and nine produced qualifying readings. I find that newly submitted arterial blood gas testing supports total disability.

Dr. Rasmussen opined that the Claimant has "evidence of probable cor pulmonale" under § 718.204(b)(2)(iii). A physician's opinion may be given little weight if it is equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also, Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Dr. Rasmussen stated that "these studies" provide "evidence" of cor pulmonale, but he didn't explain which studies he relied upon and how those studies supported his diagnosis. He also hedged his diagnosis by stating that there was "evidence" of "probable" cor pulmonale. Noting the equivocal nature of his diagnosis, the lack of documentation of the diagnosis, Dr. Rasmussen's lack of pulmonary specialty credentials, and the fact that Dr. Rasmussen was the only physician of record to even suggest that cor pulmonale could be present, I give little weight to Dr. Rasmussen's diagnosis of "probable" cor pulmonale, and find that total disability is not established under § 718.204(b)(2)(iii).

Under § 718.204(b)(2)(iv) total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

The hospitalization records and the opinion of Dr. Caffrey do not state an opinion on the issue of total disability. A physician's report which is silent as to a particular issue is not probative of that issue. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Dr. Sundaram, who lists no pulmonary specialty credentials, opined that the Miner is totally disabled. While he noted a "history" of smoking, he opined that the Miner's "problems lays

[sic] from his long exposure to coal dust of 21½ years. … Mr. Taylor's disability would be due to his underlying condition of coal workers' pneumoconiosis." Dr. Sundaram does not list the basis of his diagnosis, offers no objective evidence to support his findings, nor does he explain why coal dust is the cause of the diagnosed disability when the Miner also had a 60+ pack year smoking history. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984); *Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1095); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his diagnosis). Noting the conclusory nature of his report and his lack of pulmonary specialty credentials, I give Dr. Sundaram's opinion less weight.

Dr. Rasmussen, who lists no medical specialty credentials, opined that pulmonary function testing, arterial blood gases, and an EKG indicated that "this patient would be totally disabled from resuming his last regular coal mine job." He listed the cause of the total pulmonary disability as hyperactive airways disease aggravated by both cigarette smoking and coal dust exposure.

In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), the Court set forth the standard for establishing that a miner's total disability is due to pneumoconiosis and stated the following:

> [A] Claimant must demonstrate by a preponderance of the evidence that pneumoconiosis is 'more than merely a speculative cause of his disability,' but instead 'is a contributing cause of some discernible consequence to his totally disabling respiratory impairment.' (Citation omitted). To the extent that the Claimant relies on a physician's opinion to make this showing, such statements cannot be vague or conclusory, but instead must reflect reasoned judgment. (Citation omitted).

Dr. Rasmussen specifically opined that the Miner has a "history suggestive of hyperactive airways disease, which, in fact could make him more vulnerable to the adverse effects of both cigarette smoking and coal mist dust exposure" (emphasis added). I find Dr. Rasmussen's opinion to be equivocal and his statement that the Miner's condition "could" be aggravated by coal dust to be merely a speculative cause of the Miner's disability. Noting Dr. Rasmussen's lack of pulmonary credentials, I give little weight to his opinion.

Dr. Westerfield, a Board-certified Internist, Pulmonologist, Medical Examiner, Sleep Medicine Specialist, and B reader, performed two records reviews and opined that the Miner is totally disabled due to asthma aggravated by cigarette smoking. He based his total disability finding on pulmonary function studies and arterial blood gas evidence. He based his cigarette smoking etiology on an absence of positive x-rays and on hypercarbia (elevated CO_2) demonstrated by arterial blood gas testing. With a history of asthma, the absence of infiltrates, and continued cigarette smoking, "it is highly unlikely that this deterioration of lung function would be related to his prior history of coal mining." Dr. Westerfield utilized objective testing to make his diagnosis and documented his etiology determination through explanation of which testing results supported his opinion. Noting Dr. Westerfield's superior credentials, I give his opinion substantial weight.

Dr. Fino, a Board-certified Internist and Pulmonologist, opined that the Miner was totally disabled due to chronic obstructive pulmonary disease as a result of cigarette smoking. He based his disability opinion on pulmonary function and arterial blood gas results. He made his smoking etiology determination based on negative x-ray evidence, on pulmonary function testing showing obstruction, and on arterial blood gas testing showing hypercarbia. He then described in great detail how pulmonary function testing supported a smoking etiology over a coal dust-related etiology, how hypercarbia (or elevated CO_2) was consistent with smoking but inconsistent with occupational lung disease, and then went into an extensive discussion of the medical literature available on obstruction in coal miners and why the studies cited supported a smoking etiology.

Dr. Fino utilized objective testing to form his diagnosis, discussed in detail which readings supported his diagnosis, and documented how medical literature further supported his etiology determination. Noting Dr. Fino's superior credentials, I give his opinion substantial weight.

Dr. Dahhan, a Board-certified Internist and Pulmonologist, opined that he was unable to complete pulmonary function testing on the advice of the Claimant's primary care physician. "[D]irect measurement of his true ventilatory capacity is not possible." He hypothesized, however, that the Miner would be unable to return to his previous coal mine employment due to obstructive airway disease caused by smoking. He based his findings on negative x-rays for infiltrates, lack of exposure to coal dust since 1985 with ongoing heavy smoking, a current medical therapy which includes multiple bronchodilators and

anti-asthma medication, a therapy which is inconsistent with the permanent, fixed adverse effects of coal dust, and a carboxyhemoglobin level consistent with two packs of cigarettes per day contradicting the Miner's claim that he had stopped smoking. Dr. Dahhan's opinion is supported by objective evidence. He thoroughly discussed why the Miner's cigarette smoking caused total disability instead of coal dust exposure, while conceding that he was unable to objectively measure total capacity and, therefore, total pulmonary disability. It is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, *i.e.*, x-ray, blood gas, and ventilatory studies. *Minnich v. Pagnotti Enterprises, Inc.* 9 B.L.R. 1-89, 1-90 n. 1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985). Dr. Dahhan's opinion is supported by limited objective data as he was unable to rely on pulmonary function testing. Noting Dr. Dahhan's superior credentials, I give his opinion some weight.

Dr. Branscomb, a Board-certified Internist and B reader, opined that the Miner is totally disabled due to chronic obstructive pulmonary disease caused by asthmatic bronchitis and cigarette smoking. He based his opinion on negative x-ray and CT scan evidence for infiltrates, symptoms, and a "very severe smoking addiction plus a history of severe asthma and a positive family history of asthma and allergies." A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.* Dr. Branscomb based his disability findings on limited objective data, without listing any pulmonary function or arterial blood gas studies relied on. *Minnich, Wetzel, supra*. I give his opinion some weight.

Dr. Baker, who lists no medical specialty credentials, opined that it was difficult to assess total disability due to lack of pulmonary function testing, but stated that arterial blood gas readings with symptomatology provided enough information to diagnose the Claimant totally disabled. He opined that the Miner's disability was due to a combination of coal dust and cigarette smoking. The establishment of total disability due to pneumoconiosis requires more than mere speculation and more than conclusory statements must support a physician's diagnosis. *Grundy Mining Co., supra.* Dr. Baker offers no explanation why the Miner's disability was caused by coal dust and cigarette smoking. He relies on symptoms that were self-reported by the Miner, while failing to explain the Miner's normal chest examination in light of symptoms of cough,

sputum, and wheezing. Noting Dr. Baker's lack of pulmonary credentials, the unreasoned nature of his etiology determination, and the limited objective evidence upon which he based his disability determination, I give his opinion less weight.

Under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock, supra.* The Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *Jewell Smokeless Coal Corp., supra.*

Pulmonary function testing and arterial blood gas testing support total pulmonary disability. The well-reasoned opinions of Drs. West, Fino, and Dahhan, all Pulmonary Specialists, state, however, that the Claimant's disability is due to cigarette smoking and not coal dust exposure. This finding is corroborated by the opinion of Dr. Branscomb, an Internist. The opinions of Drs. Sundaram, Rasmussen, and Baker, who list no pulmonary credentials, are not well reasoned.

The newly submitted evidence, considered in conjunction with the previously submitted evidence, establishes total pulmonary disability under § 718.204(b)(2). The Claimant has not established, however, that pneumoconiosis is a substantially contributing cause of his total disability under § 718.204(c).

VI. Entitlement

Dallas L. Taylor, the Claimant, has not established entitlement to benefits under the Act.

VII. Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claim of Dallas L. Taylor for benefits under the Act is hereby DENIED, and it is further,

ORDERED that Sharondale Corporation is DISMISSED as a party to this claim.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.